



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Licensure and Regulatory Services
255 Rockville, 2nd Floor
Rockville, Maryland 20850
240-777-3986 Fax 240-777-3088

HOSPITAL, NURSING HOME, AND DOMICILIARY LICENSE APPLICATION

Application is hereby made for a license to operate a Hospital, Nursing Home, or Domiciliary in Montgomery County, Maryland.

(Please Print)

TODAY'S DATE _____

☐ New ☐ Renewal ☐ Change of Ownership ☐ Name Change ☐ Bed Increase

Note: A **Use & Occupancy Certificate** must accompany this application, if applying for a new facility.

Name of Institution: _____

Address of Institution: _____

Street Number and Street Name

City _____ State _____ Zip Code _____ Telephone #: _____
(Include Area Code)

Director or Administrator: _____ Telephone #: _____
(Include Area Code)

Fax Number: _____ Email Address: _____
(Include Area Code)

Person to Contact to Schedule Inspections: _____ Telephone #: _____
(Include Area Code)

Name of Owner: _____ Telephone #: _____
(Include Area Code)

Federal Tax Identification #: _____

Owner's Address _____
Street Number and Street Name

City _____ State _____ Zip code _____
Fax Number: _____ Email Address: _____
(Include Area Code)

Type of Institution: (Please check one): ☐ Hospital ☐ Nursing Home ☐ Domiciliary Care

Type of Care Provided : _____

Bed Capacity (excluding bassinets): _____ Number of Bassinets: _____

Signature: _____ Title: _____

Print Name: _____

OFFICE USE ONLY

Receipt Number: _____

Date Issued: _____

Amount Paid: _____

Date Expires: _____

Check/Money Order Number: _____

Record Number: _____

Fee Information: [Link to Fee Schedule](#). License Fee: _____ Other Fee(s) (if any): _____ Total Due: _____

Please Note: If an annual renewal application is filed after the license has expired, a **late fee of \$100.00** will be charged in addition to the annual renewal fee.

Payment Method

☐ Check ☐ Money Order (No cash is accepted) ☐ Visa ☐ MasterCard (No other credit cards are accepted)

Organization: _____ Cardholder's Name: _____

Credit Card No: _____ Exp. Date: _____ Amt \$: _____

I agree to pay the above total amount according to the card issuer agreement.

Cardholder's Signature: _____

Submit completed application and application fee to address at the top of the application. Checks or money orders are payable to "Montgomery County, Maryland".